

EXHIBIT. D

CAMPBELL CAMPBELL EDWARDS & CONROY
PROFESSIONAL CORPORATION

ONE CONSTITUTION PLAZA
THIRD FLOOR
BOSTON, MA 02129
TEL: (617) 241 3000
FAX: (617) 241 5115



ADAM A. LARSON
(617) 241-3036
alarson@campbell-trial-lawyers.com

September 29, 2006

Joseph M. Mahaney, Esq.
Goguen, McLaughlin, Richards & Mahaney, P.C.
The Harrier Beecher Stowe House
2 Pleasant Street
South Natick, MA 01760

Re: Steven McDermott et al. vs. FedEx Ground Package System, Inc. et al.
U.S.D.C. District of Massachusetts C.A. No.: 1:04-CV-12253-JLA

Dear Joe:

This will confirm that we have provided you on August 9, 2006 with a HIPAA release for Dr. Krishna Nirmel's records for your client's signature. As of today, we have not received the signed HIPAA release.

Also, enclosed please find HIPAA releases for the following providers, which have refused to release plaintiff's medical records unless provided with a signed HIPAA release:

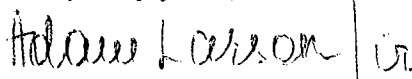
1. Herbert Cares, M.D.;
2. Surgical Neurology;
3. Nancy Altman; and
4. Wayside Metrowest Counseling Center.

Please forward the signed releases to my attention at your earliest convenience as it takes time to obtain the records.

If we do not receive the signed releases within one week, we will file a motion for a Court Order to obtain one.

Thank you.

Very truly yours,


Adam A. Larson

/ir
Enc.

cc: Michael Brown, Esq.

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Krishna N. Nirmel, M.D. to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name
1 Constitution Plaza Boston MA 02129
Address City State Zip

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

<input checked="" type="checkbox"/> Complete Records	<input checked="" type="checkbox"/> X-Ray
<input checked="" type="checkbox"/> Abstract	<input checked="" type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Pathology
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Physical Therapy
<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Emergency Reports
<input checked="" type="checkbox"/> Consult	<input checked="" type="checkbox"/> Psychotherapy Records
<input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital
or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

**IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL
NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Herbert Cares, M.D. to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
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Address: 175 Mechanic Street
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Name

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Address	City	State	Zip

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<input checked="" type="checkbox"/> Complete Records <input checked="" type="checkbox"/> Abstract <input checked="" type="checkbox"/> Face Sheet <input checked="" type="checkbox"/> Discharge Summary <input checked="" type="checkbox"/> History and Physical <input checked="" type="checkbox"/> Consult <input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> X-Ray <input checked="" type="checkbox"/> Laboratory <input checked="" type="checkbox"/> Pathology <input checked="" type="checkbox"/> Physical Therapy <input checked="" type="checkbox"/> Emergency Reports <input checked="" type="checkbox"/> Psychotherapy Records <input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>
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7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

11. _____
Relationship to patient or authority to act for patient

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NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Surgical Neurology to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name
1 Constitution Plaza Boston MA 02129
Address City State Zip

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

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<input checked="" type="checkbox"/> Abstract	<input checked="" type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Pathology
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or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.

9. _____ 10. _____
Signature of Patient or Legal Representative Date

Steven McDermott 11. _____
Printed name of patient Relationship to patient or
or patient's representative authority to act for patient

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NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Nancy Altman to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name
1 Constitution Plaza Boston MA 02129
Address City State Zip

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

<input checked="" type="checkbox"/> Complete Records	<input checked="" type="checkbox"/> X-Ray
<input checked="" type="checkbox"/> Abstract	<input checked="" type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Pathology
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Physical Therapy
<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Emergency Reports
<input checked="" type="checkbox"/> Consult	<input checked="" type="checkbox"/> Psychotherapy Records
<input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital
or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.

9. _____ Signature of Patient or Legal Representative	10. _____ Date
<u>Steven McDermott</u> Printed name of patient or patient's representative	11. _____ Relationship to patient or authority to act for patient

**IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL
NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Wayside Metrowest Counseling Center to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name
1 Constitution Plaza Boston MA 02129
Address City State Zip

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

<input checked="" type="checkbox"/> Complete Records	<input checked="" type="checkbox"/> X-Ray
<input checked="" type="checkbox"/> Abstract	<input checked="" type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Pathology
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Physical Therapy
<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Emergency Reports
<input checked="" type="checkbox"/> Consult	<input checked="" type="checkbox"/> Psychotherapy Records
<input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital
or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.

9. _____ Signature of Patient or Legal Representative	10. _____ Date
Steven McDermott Printed name of patient or patient's representative	11. _____ Relationship to patient or authority to act for patient

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NUMBERED ENTRIES ARE COMPLETED**

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THIRD FLOOR
BOSTON, MA 02129
TEL: (617) 241 3000
FAX: (617) 241 5115



MICHAEL R. BROWN
(617) 241-3041

November 3, 2006

Via Facsimile and First Class Mail

Joseph M. Mahaney, Esq.
Goguen, McLaughlin, Richards & Mahaney, P.C.
The Harrier Beecher Stowe House
2 Pleasant Street
South Natick, MA 01760

**Re: Steven McDermott vs. FedEx Ground and Mr. Pruitt
U.S.D.C. District of Massachusetts C.A. No.: 04-CV-12253**

Dear Joe:

In follow-up to our conversation this afternoon, please find enclosed the following releases:

1. Herbert Cares, M.D.
2. Surgical Neurology;
3. Nancy Altman;
4. Wayside Metrowest Counseling Center;
5. Krishna Nirmel, M.D.; and
6. Social Security Administration.

Please provide signed releases at your earliest convenience. In addition, I understand that you will provide me with all outstanding discovery responses by Monday, November 6. Pursuant to our conversation, I will file a Motion to Compel the responses if you cannot provide them to me by that date.

As we further discussed, you intend to file your Amended Complaint by Monday or Tuesday, November 7, 2006. Please provide this office with the Amended Complaint prior to filing it with the court. Thank you. Please let me know if you have any questions.

Very truly yours,

A handwritten signature in black ink, appearing to read "Michael R. Brown", written in a cursive style.

Michael R. Brown

MRB

Enclosures

cc: James M. Campbell, Esquire
Adam A. Larson, Esquire

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO	1814
RECIPIENT ADDRESS	915086511128#7603
DESTINATION ID	
ST. TIME	11/03 17:09
TIME USE	02'51
PAGES SENT	10
RESULT	OK

CAMPBELL CAMPBELL EDWARDS & CONROY
PROFESSIONAL CORPORATION
TEL: 617-241-3000
FAX: 617-241-5115

FACSIMILE COVER SHEET

DATE: November 1, 2006
TO: Joseph M. Mahaney, Esq.
FAX NO.: (508) 651-1128
FROM: Michael R. Brown, Esq.
CASE NO.: 1322-16
RE: Steven McDermott et al vs. FedEx Ground et al
PAGES: 10 (including cover sheet)

COMMENTS:

THIS TELECOPY IS SUBJECT TO THE ATTORNEY-CLIENT PRIVILEGE AND CONTAINS CONFIDENTIAL INFORMATION FOR THE PERSON(S) NAMED ABOVE. ANY DISTRIBUTION, COPYING OR DISCLOSURE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS TELECOPY IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY BY TELEPHONE AT THE ABOVE TELEPHONE NUMBER.

Social Security Administration

Consent for Release of Information

Please read these instructions carefully before completing this form.

When To Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or insurance company).

Natural or adoptive parents or a legal guardian, **acting on behalf of a minor**, who want us to release the minor's:

- nonmedical records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F3. You can get this form at any Social Security office.

How To Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB content number.

TIME IT TAKES TO COMPLETETHIS FORM—We estimate that it will take you about 3 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Form Approved

OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name Steven McDermott Date of Birth Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Adam A. Larson, Esq. Campbell Campbell Edwards & Conroy, P.C	1 Constitution Plaza, Boston, MA 02129

I want this information released because:

Civil Litigation
Civil Action Number: 0606-CV-056

(There may be a charge for releasing information.)

Please release the following information:

- ☒ Social Security Number
☒ Identifying information (includes date and place of birth, parents' names)
☒ Monthly Social Security benefit amount
☒ Monthly Supplemental Security Income payment amount
☒ Information about benefits/payments I received from 1998 to present
☒ Information about my Medicare claim/coverage from 1998 to present
(specify)
☒ Medical records
☒ Record(s) from my file (specify)
 Other (specify)

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____
SSA-3288 Internet (12/99)

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Nancy Altman to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.
2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019
3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name

<u>1 Constitution Plaza</u>	<u>Boston</u>	<u>MA</u>	<u>02129</u>
Address	City	State	Zip
4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

<input checked="" type="checkbox"/> Complete Records	<input checked="" type="checkbox"/> X-Ray
<input checked="" type="checkbox"/> Abstract	<input checked="" type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Pathology
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Physical Therapy
<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Emergency Reports
<input checked="" type="checkbox"/> Consult	<input checked="" type="checkbox"/> Psychotherapy Records
<input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>
5. The above information is disclosed for the following purposes: (circle appropriate categories)
Medical Care Legal Insurance Personal At request of the individual Other _____
6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital
or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.
7. This authorization expires upon termination of the litigation.
8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.
9. _____
Signature of Patient or Legal Representative
10. _____
Date
11. _____
Relationship to patient or
authority to act for patient

**IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL
NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Wayside Metrowest Counseling Center to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name
1 Constitution Plaza Boston MA 02129
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(circle appropriate categories)

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9. _____ Signature of Patient or Legal Representative	10. _____ Date
<u>Steven McDermott</u> Printed name of patient or patient's representative	11. _____ Relationship to patient or authority to act for patient

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**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Krishna N. Nirmel, M.D. to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [REDACTED]
Social Security #: [REDACTED]
Address: 175 Mechanic Street
Bellingham, MA 02019

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Address City State Zip

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same full force and effect as if it were itself the original.

9. _____ 10. _____
Signature of Patient or Legal Representative Date

Steven McDermott 11. _____
Printed name of patient Relationship to patient or
or patient's representative authority to act for patient

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NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Surgical Neurology to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
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Bellingham, MA 02019

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Signature of Patient or Legal Representative

10. _____
Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

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NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize Herbert Cares, M.D. to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
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Date of Birth: [REDACTED]
Social Security #: [REDACTED]
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<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Emergency Reports
<input checked="" type="checkbox"/> Consult	<input checked="" type="checkbox"/> Psychotherapy Records
<input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital
or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

**IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL
NUMBERED ENTRIES ARE COMPLETED**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH
INFORMATION**

1. I hereby authorize _____ to use or disclose the
(Name of hospital/physician)
following protected information from the records of the patient listed below. I understand that information
used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,
may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Stacey L. McDermott
Date of Birth:
Social Security #:
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name
1 Constitution Plaza Boston MA 02129
Address City State Zip

4. Disclose the following information for treatment dates: 1994 to Present
(circle appropriate categories)

<input checked="" type="checkbox"/> Complete Records	<input checked="" type="checkbox"/> X-Ray
<input checked="" type="checkbox"/> Abstract	<input checked="" type="checkbox"/> Laboratory
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Pathology
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Physical Therapy
<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Emergency Reports
<input checked="" type="checkbox"/> Consult	<input checked="" type="checkbox"/> Psychotherapy Records
<input checked="" type="checkbox"/> Outpatient Reports	<input checked="" type="checkbox"/> Other specified <i>*All radiology films</i>

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital
or physician practice in writing unless action has already been taken in reliance upon it, or during a
contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the
same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

Stacey L. McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

**IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL
NUMBERED ENTRIES ARE COMPLETED**